Practice Standards & Administrative Guidelines

for HIV Related Case Management

PRACTICE STANDARDS AND ADMINISTRATIVE GUIDELINES

FOR HIV-RELATED CASE MANAGEMENT

Wisconsin AIDS/HIV Program
Bureau of Communicable Diseases
Division of Public Health
Wisconsin Department of Health and Family Services

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Forward

This document is the result of the efforts of several groups that, over the course of many years, were committed to developing quality services for persons with HIV infection in Wisconsin. The focus of their efforts was defining HIV psychosocial case management practice standards and administrative guidelines in order to establish a framework for statewide HIV-related case management services.

In 1991, The Wisconsin AIDS/HIV Program established a Case Management Workgroup to develop case management practice standards to be utilized by Wisconsin AIDS service organizations in providing case management services to persons with HIV infection. Recognizing the importance of administrative support and supervision of case management services in local ASOs, the Workgroup developed administrative guidelines that identify specific administrative components of case management.

In 1993, the *Practice Standards and Administrative Guidelines for HIV-Related Case Management* underwent minor revisions and expanded to include standard case management forms. Since that time, case management services have evolved to include a broader array of agencies providing case management services and ever-increasing numbers and diverse groups of persons receiving these services.

In 2001, the Wisconsin AIDS/HIV Program convened a Case Management Standards Revision Workgroup for purposes of reviewing and revising the *Practice Standards and Administrative Guidelines for HIV-Related Case Management*. This Workgroup focused on differentiating levels of case management services based on client need and case management resources. As a result, the Workgroup developed an acuity tool to be used as part of a comprehensive assessment. The Workgroup also developed assessment questions for adolescent and youth to target services to meet changing psychosocial needs.

The Wisconsin AIDS/HIV Program gratefully acknowledges the efforts and commitment of the following members of the most recent Standards Revision Workgroup: Debbie Bonilla, Angela Brautigam, Laura Brokl, Barb Cuene, Char Crabb, Ann Fleming, Kathy Fox, Roma Hanson, Maggie Kennedy, Miche Llanas, Sylvia Lee-Thompson, Michael McFadden, Gail Nahwahquaw, Bill Paul, Pam Rogers, Jim Stodola, and Cheryl Thiede.

The Wisconsin AIDS/HIV Program also gratefully acknowledges the AIDS Foundation of Chicago-Northeastern Illinois HIV/AIDS Case Management Cooperative and the San Francisco Health Services Planning Council, the California Department of Public Health Office of AIDS, and local task force members for use and adaptation of acuity tools developed by these groups.

The Wisconsin AIDS/HIV Program recognizes that case management standards and guidelines will continue to evolve based on knowledge and experience gained in the future. The AIDS/HIV Program supports full implementation of the standards and guidelines and invites comments and suggestions on this document. For more information, to obtain additional copies, or to submit comments, contact the AIDS/HIV Program by phone at 608/267-5287, by fax at 608/266-2906, email nahwag@dhfs. state.wi.us or write to:

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1.0 BACKGROUND

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1.2 TERMINOLOGY

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1.1 INTRODUCTION

Over the past two decades, much has changed and significant advances have been made in HIV / AIDS prevention, care and treatment. The utilization of highly active antiretroviral therapy (HAART) has resulted in HIV disease being recognized and managed medically as a chronic illness.

HIV service agencies are incorporating programs such as return-to-work into their continuum of services for HIV positive persons. These programs and others focus on assisting clients with long term issues other than those surrounding concerns with an initial HIV diagnosis. However, segments of the community continue to struggle with access to prevention education, case management, primary medical care and medication.

> Case management services focus on assisting clients with complex health and human service needs in utilizing resources needed to function independently in a community of one's choice as long as practical. Clients frequently enter into HIV case management services with increasingly complex bio-psychosocial needs. HIV is just one of many issues faced by clients and it may not be their primary concern even though it may intensify other existing needs or issues.

This document focuses primarily on traditional HIV psychosocial case management rather than that of HIV prevention case management (PCM) which has been implemented in a select number of agencies in Wisconsin since 1999. PCM uses a long-term counseling relationship to develop, support, and maintain behavior change efforts by individuals living with HIV to reduce the risk of transmitting the virus. HIV case managers and prevention case managers work collaboratively to develop comprehensive service delivery mechanisms that assist clients in accessing unduplicated targeted services.

1.2 TERMINOLOGY

A glossary at the end of this document defines key terms and concepts in this document.

1.3 CASE MANAGEMENT DIVERSITY

HIV case management services are provided to diverse populations in a variety of settings. To address this, HIV case management standards are defined broadly.

1.4 INTENDED USE OF THE STANDARDS

Adherence to these standards by all individuals providing case management services ensures quality case management services that are consistent and that can be evaluated for effectiveness.

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2.1 DEFINITION OF CASE MANAGEMENT

Case management is an approach to service delivery which strives to ensure that clients with complex needs receive timely coordinated services and that resource links are made and utilized to maintain an individual's ability to function independently in a community of their choice as long as practical. Case management involves the active participation of the client or the client's designated representative in all aspects of the case management process. Case management encourages collaboration, cost efficiency, and service integration to avoid service duplication. Case management is a mechanism for serving persons with chronic conditions and those with multiple service needs or who lack systematic access to services.

2.2 PHILOSOPHY OF CASE MANAGEMENT

Case management services affirm a client's right to:

- a quality life
- privacy
- confidentiality
- self-determination
- nondiscrimination
- compassionate non-judgmental care
- dignity and respect
- quality case management services

2.3 ROLE OF CASE MANAGER

The key functional role of the HIV case manager is coordination or arrangement of services (formal or informal) across service settings. The foundation is effective communication between the case manager, the client, coworkers and interagency referral staff. This can bridge gaps between the case manager, consumer, and other service providers. Case managers must maintain a balance between coordination and advocacy while building trust and helping clients in their own self-empowerment. Case managers lead in coordinating services and encouraging active client participation in service delivery, while maintaining a balance between advocacy and promoting client self-empowerment.

In addition to the primary role of service coordination, case managers assume a variety of roles which complement coordination such as:

- negotiation and advocacy for the development and delivery of needed services
- navigation and direction for clients seeking access to services
- education to and consultation with consumers and professionals concerning HIV disease and case management

- psychosocial support of affected individuals and family members

- awareness and collaborative use of community resources for appropriate linkages assuring a comprehensive response to client needs (*Encourage collaborative efforts to effectively meet the needs of consumers)*

2.4 CORE FUNCTIONS & KEY ACTIVITIES

The case management process involves six core functions that assess client needs and assist the client in gaining access to needed services. These include:

- Intake
  Screening and evaluating eligibility, disseminating program information, agency capacity and limitations.

- Assessment
  Evaluating and prioritizing human needs.

- Service plan development
  Facilitating client access to and enhancing services.

- Monitoring and evaluation
  Collecting and monitoring data to ensure that services provided are consistent with the service plan.

- Reassessment
  Reevaluating client needs/strengths and the service plan annually or when there are changes in a client's life.

- Discharge/Transfer
  Formal notification that a client can no longer obtain case management services from the current service provider.

2.5 GOALS OF CASE MANAGEMENT

The major goals of HIV case management include:

- integration of services across an array of service settings, supported by interagency collaboration when appropriate

- increased access to needed services

- continuity of care

- enhanced independence and increased quality of life

- increased knowledge regarding the impact of HIV disease on one's health and the importance of positive health behaviors

3.0 STANDARDS & GUIDELINES

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3.1 FORMAT OF STANDARDS

Case management standards are formatted to reflect the core functions and guidelines of case management. The format is as follows:

Standard:	A statement of expected performance or client outcome as it relates to the core functions of case management.
Interpretation:	Detailed explanation of the standard.
Key steps:	The process or activities conducted to accomplish a standard.
Criteria:	The measure against which a standard is evaluated.
Documentation:	Required recording indicating that a standard is met.

3.2 STANDARDS & CRITERIA

3.2.1 INTAKE

Standard: Persons referred for case management services will be screened and evaluated for eligibility to receive case management services.

Interpretation: Prospective clients who request or are referred for case management services are screened and evaluated for eligibility through an information gathering and assessment process.

Key Steps:

1. Intake is initiated by a request from a prospective client or guardian or third party referral (verified verbally by the client).

2. A professional case manager or a volunteer with appropriate professional experience screens the service request/referral against admission criteria and assesses the need for immediate intervention. Staff are prepared to handle crisis situations as they arise.

3. Critical demographic and case specific information is collected directly or indirectly from the prospective client/referral source and the prospective client is informed of agency services and limitations.

4. An intake worker or appropriate case management staff contacts non-enrolling consumers at least once in the first quarter after initial contact to reassess consumer need for case management service and invite enrollment if necessary.

Criteria:

1. Within 2 working days of receipt of referral or client-initiated contact, the client is offered an appointment for intake.

2. Intake is initiated through contact with the prospective client within seven (7) working days of the referral or self-referral. When intake determines client eligibility, the client is offered immediate enrollment in case management to conduct a comprehensive needs assessment and service plan development. If the individual chooses to decline case management enrollment, staff discuss follow-up and get contact information.

3. Case management staff conducting intake provide a prospective client a description of the services available from the HIV case management agency. The limitations of case management service and the role of the case manager are also highlighted.

4. When an assessment appointment can not be arranged upon completion of the intake process, the client is informed which case management staff will be contacting the client to arrange assessment and when this will occur.

Documentation:

1. The client record includes documentation of the following:

   a. client name

   b. county of residence

   c. documentation of HIV status (and, if possible, source of test, where performed and when)

   d. method of communication to be used for follow-up

   e. source of referral and date

   f. presenting problems identified by client, guardian or primary care giver

   f. status of crisis interventions, referrals and follow-up responsibility

   g. individuals aware of client's HIV status

   h. client’s choice concerning management of confidential and personal information

   i. the decision of the prospective client and intake staff regarding enrollment and/or referral

3.2.2 ASSESSMENT

Standard: Assessment is a cooperative and interactive process between a client and case manager during which they collect, analyze, synthesize and prioritize information which identifies client needs, resources, and strengths for purposes of developing a service plan. Secondary data is frequently gathered from health and human service professionals and other individuals.

Interpretation: Assessment is conducted through one or more face-to-face interviews between the client, guardian, or client representative and case manager and through collaboration with health and human service professionals and other individuals involved in a client's life. Assessment includes a variety of information/data collection methods, including face-to-face interview with the client, conducting an acuity assessment, review of client service records, interviews with health and human service professionals, interaction with members of the client's social network, and acquisition of supplementary assessments/ evaluations.

Assessment identifies the:

- extent and nature of client needs
- client's ability to meet personal needs
- capacity of the client's social network to address client needs
- capacity of available human services to address client needs
- level of case management service. (low, moderate, or high)

Key Steps:

1. Assessment is conducted by case managers in HIV case management provider agencies based on established policies and procedures. For children and adolescents, the parent(s) or primary care giver(s) is consulted. Adolescents actively participate in their assessment. Other staff members or a volunteer with appropriate professional experience may assist with this process.

2. The face-to-face interview is conducted at a site that is mutually acceptable to the client and case manager and one that ensures client confidentiality.

3. The process of identifying client needs and strengths involves client self-assessment and supports client self-determination. Equally important is ongoing collaboration between the case manager and other health and human service providers and individuals actively involved with the client, through collateral contacts, interdisciplinary team meetings, and record reviews.

Criteria:

1. Unless otherwise noted in the client record, within 2 working days following intake and determination of eligibility for case management services, a client is offered an assessment appointment. An assessment is usually conducted in one to two face-to-face meetings between the client and case manager, commencing no later than seven days following intake.

2. After a client's case is officially opened, a comprehensive client assessment is conducted by the designated case manager or other appropriate staff.

3. Client needs are systematically assessed, documented, and summarized. This involves the active participation of the client, health and human service professionals and other individuals agreed to by the client in the following areas:

   a. income/assets

   b. financial resources (identification of and coordination with insurance, veterans' benefits, and other sources of financial assistance)

   c. housing/shelter

   d. employment

   e. educational status (if the client is a minor assess daily structure and who at school knows client's HIV status) If appropriate, prognosis for employment; educational/ vocational needs; appropriateness and/or availability of educational, rehabilitation and vocational programs. Literacy and communications skills are assessed through this process.

   f. physical and dental health assessments, consideration of potential for rehabilitation

   g. mental health and emotional status

   h. as required under Wisconsin statute 49.45 (25), record of a multidisciplinary team evaluation for any client under age 21 and who is identified as severely emotionally disturbed

   i. cultural, ethnic, or racial considerations including primary language usage and interpreter/translation service needs

   j. social relationships and support (informal care givers; formal service providers; significant issues in relationships, social environments)

k. client's perception of physical environment, especially regarding mobility in home and accessibility

l. recreation and leisure (hobbies)

m. activities of daily living

n. transportation

o. legal status, if appropriate (power of attorney, living will, permanency planning, involvement with the legal system)

p. spirituality/religion

q. self-care knowledge, assets, and limitations including HIV transmission and risk reduction strategies (If the client is a minor, assessing age appropriate risk behavior strategies and ongoing HIV education)

r. accessibility to community resources which the recipient needs or wants

s. assessment of drug and/or alcohol use and misuse

t. other areas as appropriate

4. An acuity assessment is completed simultaneously and will help determine the appropriate level of service for the client.

5. The client is informed of rights and responsibilities in case management in accord with written policies and procedures established by each respective HIV case management provider agency. The client is fully informed of the internal and referral programs available and provided external resources for other community service needs.

Documentation:

1. The client record must include documentation of the following:

a. summary of key personal data

b. assessment summary

c. a scored acuity assessment

d. priority and/or problem list

e. bio-psychosocial and health assessments conducted face-to-face with the case manager

f. secondary assessment data acquired from other professionals and sources

g. signed release of information forms for collateral contacts

h. if self-reporting HIV verification, arrangements are made to have a copy of this verification within 30 working days of case management enrollment. Acceptable verification includes:

- copy of the client's validated positive HIV test result (e.g., ELISA/Western Blot or other confirmatory tests)

- signed document from a physician verifying client's HIV status

3.2.3 SERVICE PLAN DEVELOPMENT

Standard: A client service plan is created by systematically identifying client needs based on information exchanged during intake and assessment.

Interpretation: The client service plan is a case management workplan that systemically identifies client needs based on the information exchange during intake and a comprehensive client assessment. The major components of the service plan include identification of priority client needs, service goals, and quantified time-specific objectives, and action steps. The purpose of the service plan is to facilitate client access to services and to enhance coordination of care to help maintain client health and independence. The service plan also ensures case management accountability.

Development of the client service plan is an interactive process between the case manager and the client. The process supports client self-determination whenever possible and empowers a client to participate actively in the planning and delivery of services. Under certain circumstances (e.g., client neurologic impairments, crisis situations, etc.), decision making may be deferred to a representative legally designated by the client along with the case manager serving as an adviser if requested. It is the professional responsibility of the case manager to analyze client needs and to discuss service plan alternatives with the client. This includes discussion of anticipated outcomes or consequences in choosing alternatives for the service plan.

The role of the case manager is primarily one of resource coordination. The service function of case management is a process of contacting both formal and informal providers to arrange for services outlined in the service plan.

When, during service plan development, specific knowledge and/or skills are needed beyond those of the case manager, consultation with other professionals is obtained and the case manager documents this in the client record.

The service plan is structured, documented, time-specific, and on-going. It specifies the method of measurement and provides the basis for determining the effectiveness of case management and the rationale for the purchase of or referral for services.

Key Steps:

1. Service plan development is conducted with client collaboration by case managers in HIV service provider agencies and is performed in accord with written policies and procedures established by each respective agency. For children and adolescents, the parent(s) or primary care giver(s) is consulted in service plan development. Adolescents actively participate in the development of their service plan. After completing the

assessment, the case manager develops a problem list of priority client needs.

2. The service plan is developed in consultation with the client by the designated case manager who:

- prioritizes client needs to be met through case management;
- establishes measurable short and long term goals;
- establishes objectives and action steps to meet service plan goals;
- identifies formal and informal resources to accomplish goals;
- identifies payment source for services, where indicated;
- identifies gaps in services;
- identifies alternatives to meet client needs; and
- develops a brief description of problem solving methods.

3. The case manager and client review the service plan, make any needed adjustments, The client authorizes (verbal authorization is acceptable) the service plan and it is implemented. Clients receive a copy of their service plan.

4. The client or client-identified caregiver is informed about and agrees to assume responsibility for notifying the case manager about changes in the client's status or significant problems encountered in receiving needed services.

Criteria:

1. Within 7 working days following assessment, a client service plan is established by the designated case manager and recorded in the client record. Thereafter, all service plans are reviewed and renewed in accord with client level of service and documented by the assigned case manager.

2. The service plan identifies who is responsible for contacting the referral source and follow-up upon initiation of service.

Documentation:

The client record includes documentation of the following:

1. a service plan signed and dated by the case manager which includes:

- description of the priorities and/or problem(s)
- description of what is to be done, i.e. the solution

- a list of all formal and informal services to meet the need of identified problems

- the quantity, frequency, time frame, and provider of service

2. biannual supervisory review of service plan

3. notations of service plan changes signed and dated by the case manager

3.2.4 SERVICE PLAN MONITORING AND EVALUATION

Standard: Monitoring occurs to ensure that provided services are consistent with an individual case management service plan, and evaluated for effectiveness to meet client's case management need(s).

Interpretation: Monitoring is an ongoing data collection process. The frequency of monitoring is dependent on the level and intensity of client need. Monitoring involves collection and analysis of data and information, and it results in the following:

- evaluation of the effectiveness and relevance of the service plan
- evaluation of the level of client satisfaction
- measurement of client progress
- determination of the need for service plan revision

Key Steps:

1. Monitoring is conducted through:
   a. direct contact (i.e., face-to-face meetings and telephone communication) with the client, client and guardian, or guardian (In some instances, it may be helpful or necessary to conduct a home visit to directly assess a client's living environment.)

   b. indirect contact with the client, client's family and/or guardian, the primary care physician, service providers and other professionals, and with the client's environment (home or temporary residence) through meetings, telephone communications including voicemail, written reports and letters including email, review of client records and related materials, and through client or agency staffing

2. The case manager obtains information on an ongoing and periodic basis concerning:

   a. status of the client and family

   b. satisfaction of client and/or client-identified caregiver with service provision

   c. quality and appropriateness of services provided

Criteria:

1. The client or client-identified caregiver is encouraged to notify the case manager about changes in the client's status or significant problems encountered in receiving needed services.

2. Within one month following the authorization of the service plan and, depending on level of service, at least quarterly thereafter direct client contact is made by the case manager for purposes

of monitoring the client's progress and evaluating the effectiveness of the service plan. Activity level is determined, in part, by acuity assessment.

Level of Service	Frequency of Contact
Active 1(Low):	Quarterly follow-up.
Active 2(Moderate):	Monthly follow-up.
Active 3(High):	Monthly or >follow-up.

Active Level 1: A case manager-initiated direct contact with the client or designated representative occurs quarterly. (At this service level, clients have an established patient/physician relationship and/or signed release forms for medical provider case staffings to help assess medical care needs.)

Active Level 2: At least one case manager-initiated direct client contact occurs monthly unless otherwise documented with the client or client system.

Active Level 3: A case manager-initiated direct or indirect contact with the client or client system occurs monthly-- more frequent contact is preferred.

3. At least annually, each case managed client is surveyed to assess client satisfaction with case management services and services coordinated under case management.

4. Monitoring is conducted by the primary case manager or a person (designated by the primary case manager) with relevant HIV-related case management experience.

Documentation: The client record includes the following documentation (signed, dated or logged by the case manager):

1. all client contacts pertinent to service provision or referral

2. contacts with client's support system, service providers, and other participants listed in the service plan

3. services provided at intervals reflecting the outcome goals of the service plan

4. changes in service delivery and rational

5. supervisory input and formal semi-annual review

6. Non-client or other collateral contacts related to case management activities

3.2.5 REASSESSMENT

Standard: Clients are reevaluated or readmitted through a formal reassessment process that determines the client's case management status and the need for revisions in the service plan.

Interpretation: The client is reassessed and reevaluated through a formal reassessment process. Reassessment is conducted on a regularly scheduled basis, either annually or when unanticipated events or changes take place in the client's life (e.g., event-precipitated, recent hospitalization or loss of psychosocial support system).

Key Steps:

1. Reassessment is conducted by the case manager or a qualified staff person under the supervision of the case manager supervisor and is performed in accord with established standards and criteria.

2. The reassessment process may involve the collaboration between the case manager and other health and human service providers, individuals actively involved with the client, and through client record review.

3. Reassessment includes: HIV condition (symptomatic, asymptomatic, HIV or AIDS); health; mental health; risk behavior; substance use (if applicable); and service plan progress, changes, barriers and mutually agreed upon goals.

Criteria:

1. Active case managed clients are reassessed annually or more frequently as needed (e.g., event-precipitated, recent hospitalization or loss of psychosocial support system).

2. The reassessment process results in a modified service plan, which takes into consideration changes in client general condition since the last assessment.

3. Reassessment also occurs when a client is readmitted having not accessed service in the last six months or when an individual transfers into case management.

   Questions answered through reassessment include:
   a. Are there any changes in the client's physical, mental or psychosocial status since the last assessment? (If the client is a minor, reassessment may include assessment of family or other caregivers.)
   b. Should the intensity of case management services increase or decrease based on any changes in the clients bio-psychosocial status and how?
   c. Were the goals of the previous service plan achieved and to what extent?

d. What barriers existed to prevent progress on the previous service plan goals?
e. Are there new services the client should receive that were not included in the previous service plan?

4. Case management paperwork is updated and reviewed at the time of reassessment. (Client Service Agreement, Signed Release of Information, Grievance Policy, Client Rights and Responsibilities, etc.)

5. Legal documents (e.g., power of attorney, living will, and permanency plan) will be reassessed if not documented in the initial assessment.

Documentation:

1. The client record includes documentation of the following:

   a. update of personal data (contact information including, address, phone, how to contact)

   b. reassessment summary (within the reassessment and briefly noted in Progress Notes)

   c. updated list of priority needs

   d. updated bio-psychosocial and health assessments conducted face-to-face with the case manager

   e. updated secondary assessment data acquired from other professionals, and family or caregiver sources

   f. updated service plan

   g. updated acuity assessment

   h. client and case manager goals

   i. supervisor signature on service plan indicating supervisory input and review

3.2.6 DISCHARGE/TRANSFER

Standard: Clients are discharged or transferred from case management services through a systematic process that includes a formal notification to the client.

Interpretation: Clients are discharged or transferred from case management services through a systematic process which takes into account the needs and desires of the client, his/her caregivers, and, if appropriate, family and support network. Documentation in the client record includes the following:

- reason(s) for discharge/transfer
- formal notification to the client of case closure
- notification of an appeal process
- discharge summary

Key Steps:

1. Discharge or transfer is performed in accord with written policies and procedures established by each respective agency.

When to Discharge/Transfer:

a. In the case of client death:
   - Referral information about grief counseling or other support services are shared with the family and significant others.
   - Agencies will determine the timeline for bereavement support services for affected family and or significant others.

b. At the request of the client or guardian:
   - Discharge summary is completed by case manager, reviewed with the client, and reviewed and signed by case management supervisor.
   - Information about re-establishment of services is shared.

c. When clients become ineligible for services:
   - Case manager notifies case management supervisor of intent to discharge client. (Supervisory involvement on final determination of discharge takes place only when discharge is initiated by the agency.)
   - Case manager reports to supervisor on the client's situation e.g., actions and/or behaviors (verbal and/or nonverbal) that makes the client ineligible for case management services.
   - In accord with written policies and procedures established by each respective agency, the case manager notifies the client (through face-to-face meeting, telephone conversation or letter) of plans to discharge the client from case management services.
   - The client receives written documentation explaining the reason(s) for discharge and the process to be followed if client elects to appeal the reason(s) for discharge.

- Information about re-establishment of services is shared with the client.

2. Case manager will notify and verify termination of all funded or arranged services, with appropriate signed release and will complete billing requirements.

3. Case manager completes the discharge summary and it is reviewed and signed by case management supervisor and client when appropriate.

4. Appropriate referrals will be made on the client's behalf, if client so desires.

Criteria:

1. Reasons for client discharge include:
   - client relocation outside of agency service area
   - case management priority needs completely resolved
   - HIV seronegative status
   - lack of service contact, in accord with agency discharge policy
   - client decision to terminate services
   - abuse of agency staff, property or services
   - death

2. Date of discharge is established by:
   - date of client death (agency guidelines will establish bereavement support timeline)
   - date HIV case management provider agency and client or guardian agree on termination of service
   - date HIV case management provider agency determines and documents client ineligibility for case management service

3. Within 4 weeks of the final decision to terminate services, a discharge summary is completed and signed by the case manager, reviewed and countersigned by the case management supervisor, and placed in the client's record.

4. All discharges are reported in the quarter that the discharge summary is completed.

5. Client records are securely stored and retrievable by the HIV case management provider agency for a minimum of seven years following discharge.

Documentation:

The client record includes documentation of the following:

1. Progress notes reflecting action taken to close the case including:
   - reason(s) for discharge

- formal client notification of case closure and appeal process when client becomes ineligible for service

2. A completed discharge summary documenting service plan goals attained at the time of discharge, options for ongoing case management, and the process for re-engaging in case management.

3. Documentation that indicates the reason for ineligibility, if discharge is initiated by the case manager.

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4.1 INTRODUCTION

The following administrative guidelines were developed to assist Wisconsin HIV case management service providers in implementing quality case management services for persons with HIV disease. During the process of developing standards for case management services, workgroup members recognized the importance of the administrative structure supporting case management services.

These guidelines are parameters which support quality case management services and a quality work environment for case managers.

Administrators or program managers should designate lead staff responsible for implementing case management guidelines and standards. At least annually, administrative staff and case management staff should review these guidelines and the case management standards to ensure the full implementation of standardized case management services for persons with HIV disease and their families.

4.2 STAFFING

4.2.1 SUPERVISION

Case managers require a direct line supervisor for guidance, direction and support in providing case management services to persons with HIV disease. Therefore, supervisors of case managers should be skilled in directing and evaluating the scope and quality of case management services. Ideally, a supervisor should have experience in providing case management services to persons with HIV disease or other chronic illnesses. Where this is not practical, the supervisor should be an individual responsible for overseeing other employees and programs providing direct services to clients. Examples of such management staff include public health nursing supervisors and clinical social work supervisors.

The supervisor should be experienced with or know the local community resources that will be utilized by the case manager. A case management supervisor must have time to routinely review and approve case management records to facilitate the case manager's duties, and to provide routine supportive supervision to the case manager.

When a case management supervisory position is vacant or a supervisor is on annual leave (vacation, extended personal or sick leave, etc.), an interim case management supervisor should be appointed by agency administrative staff.

4.2.2 QUALIFICATIONS OF CASE MANAGERS

Case managers should have college-level academic preparation as well as related experiences in providing human services to a broad range of persons with HIV disease. At a minimum, case managers should have a baccalaureate or graduate degree in a human service discipline from an accredited college or university and a minimum of one year experience in human service delivery at a staff (salaried or volunteer) level. For individuals without related academic degrees, relevant work experience conducted under the supervision of a human service professional can be substituted. Only persons with relevant work and/or academic experience should be considered for employment.

4.2.3 SUPPORT STAFF AND RESOURCES

Case management requires extensive documentation of complex information for clients, referral resources, funding, and ongoing reporting. In order to maximize the amount of time the case management staff can spend working directly on client services, agency support (clerical) staff, volunteers, and ancillary equipment or services (laptop computers, cell phone, and pagers) should be provided. HIV case management agencies should also establish policies and procedures which inform and assist clients in obtaining emergency assistance outside regular work hours or when a case manager is unavailable. Case managers' personal telephone numbers and home addresses should be confidential and not be disclosed by anyone (including the client's actual case manager) to clients, clients' families and friends, or other interested parties.

4.2.4 VOLUNTEERS

HIV case management provider agencies should establish policies and procedures which define the following components of the agency's volunteer program:

- the roles, responsibilities, qualifications, and supervision of volunteers
- initial and ongoing training of volunteers
- agency and community supportive services for volunteers

Each volunteer should be required to sign an agreement which indicates that the volunteer understands and agrees to follow policies and procedures established by the HIV case management program, including policies regarding strict confidentiality of client information.

4.3 TRAINING

4.3.1 INITIAL TRAINING

Case managers should be provided with a structured orientation which includes:

- review of agency policy manual
- review State HIV case management standards
- training practice time, (i.e., job shadowing of current case managers)
- joint review and discussion of cases by the supervisor and new employee
- introduction to referral resources in community
- eligibility criteria for state and local funded services (case management, medical assistance, drug assistance, health insurance premium subsidy program, partner counseling and referral, and Ryan White Title II Consortium)
- case management reporting requirements
- basic and advanced information on HIV disease

4.3.2 ONGOING TRAINING

Case management staff should be provided routine and consistent in-house training related to agency policy and practices, case management skills, community resource presentations, recording/documentation, and other skill and information needs in a timely manner. Case managers should participate in training or conferences provided by the Wisconsin AIDS/HIV Program. Case managers should have access to community training deemed necessary for professional skill or service development. Staff training needs should be assessed through routine supervision, annual staff review, and new program or resource development.

4.4 AGENCY RESOURCES

4.4.1 STAFFING CONSIDERATIONS

HIV provider agencies should establish case management staffing patterns which reflect the following caseload considerations:

- availability of local resources
- complexity of human service needs of client population
- knowledge, skill level and professional experience of case management staff
- geography of the service area, and time and travel constraints in accessing or obtaining needed services
- cultural competence of staff

4.4.2 WORK SPACE

Case management staff should be provided with office space which allows them to conduct client business in a timely and confidential manner. Office space should allow the case manager to interview clients without other clients or staff present. If private office space with a door is not available, the agency must ensure that other staff or agency clients do not have access to confidential communications.

4.4.3 STRESS MANAGEMENT

Case managers working with persons with HIV disease experience high levels of stress. Client chronic illness, crises, complexity of client psychosocial issues and multiple diagnosis, heavy workload, constant time-limited tasks, and the need to work within multiple systems are a few of the issues which contribute to case manager stress. Agencies should provide case managers assistance and opportunities to manage work-related stress. This includes routine supervision, adequate work space and work environment, a system to backup staff, changes in cases or caseloads, protected work time, routine training or strategies to address stressful issues, formal or informal support groups, utilization of volunteers, ready access and referral to an employee assistance program (EAP), and adequate employee benefits (health insurance, vacation/personal time, sick leave, etc.).

4.5 CLIENT INFORMATION

4.5.1 CONFIDENTIALITY

All written and verbal communications pertaining to individual clients shall be maintained in strict confidentiality according to a written policy approved by the AIDS/HIV Program. All designated agency staff with access to client information shall receive routine training on confidentiality, the proper exchange of information, and required consent.

4.5.2 CLIENT RECORD

Agencies shall provide an appropriate storage system for client files (hard copy). The system should include, at minimum, charts which securely hold and organize materials and which are "double locked," i.e., in locked files located in a room or facility which is securely locked and prohibited from public access.

4.5.3 AUTOMATED CLIENT FILES/INFORMATION

Agencies storing client information on computer hard drive, floppy disk, or other automated systems must ensure that:

- access is blocked by a security code and limited to case management staff cleared for use
- interdepartmental systems block access between departments
- systems with modems are blocked from outside agency access
- computer firewall software restricts unathorized access to individual computers and computer networks
- case managers should provide consumers the necessary information for an educated choice regarding the security of email transmittals
- proper backup procedures are systematically followed for critical client information
- off-site backup procedures are routinely practiced
- off-site use is secure, backup disc access is password protected

4.5.4 TRANSPORTING CLIENT RECORDS AND INFORMATION

Client records which are transported outside the HIV case management provider agency should be handled in a manner which ensures absolute security and confidentiality, i.e., never left unattended, transported in a container (envelope, file, briefcase, etc.) which does not disclose client-specific information, and handled only by authorized personnel.

Client records which are transported through the US mail system or commercial carrier should be securely packaged, marked as "confidential" on the face of the package, and shipped at a rate comparable to "first class" mail or a rate which ensures faster delivery.

Client information transmitted through a facsimile (FAX) machine should only be transmitted under conditions that ensure that strict confidentiality is maintained by the agency/person receiving the client information.

4.6 CASE TRANSFER

Case managed clients should be assigned to a new case manager if appropriate after implementing the agency transfer/discharge policy and procedure process and exhausting all other options. A transfer request can be initiated by:

- a client request
- a case manager request
- the case management supervisor when he or she determines that a transfer is appropriate through routine supervision
- a client moving out of the service area
- a case manager leaving employment

Prior to transfer, the case management supervisor should ensure that:

- the client is notified of the change and name of the new contact person
- the supervisor and case manager(s) have met and discussed the client's status
- a thorough transfer summary note is completed by the case manager and logged in the client record and reviewed by the supervisor
- the former case manager is informed of agency policy regarding termination of contact with clients following case transfer
- the case manager does not remove confidential client or agency materials upon termination of employment

4.7 PROGRAM DEVELOPMENT AND EVALUATION

4.7.1 PROGRAM PLANNING

Each contracted agency should have an annual HIV case management program workplan which is developed based on a systematic planning process. Review and input on draft workplans should be obtained from case managers employed by the agency. Ongoing communication should be maintained between HIV case management staff and the Ryan White Title II HIV Consortium. Staff should coordinate program planning for case management services with related activities undertaken by the local Ryan White Title II HIV Consortium.

4.7.2 CLIENT INPUT AND FEEDBACK

Each HIV case management provider agency should conduct periodic satisfaction surveys of clients and key service providers, no less frequent than annually, to

determine the level of client and provider satisfaction with case management services provided through the agency. These surveys should be carefully reviewed by the HIV case management staff, including joint reviews by both supervisors and case managers, for purposes of making program changes to better address client case management needs.

HIV case management agencies are encouraged to establish a client advisory group which can provide formal or informal advice and recommendations regarding case management services. An advisory group should be representative of the client population being served through the respective agency and it should meet regularly for purposes of providing advice and being informed about recent developments in service delivery and client needs. Discussions and recommendations from client advisory groups should be documented in summary form and shared with all HIV case management and administrative staff.

4.7.3 CASE MANAGER PERFORMANCE EVALUATION

Each case manager should have an annual evaluation which evaluates the case manager's performance in comparison to duties and responsibilities outlined in the case manager's official position description and agency workplans. The performance evaluation should include an opportunity for the case manager and supervisor to jointly identify resources (training, materials, psychosocial support, etc.) needed for the case manager to carry out designated duties and responsibilities. The performance evaluation should include a review of past performance as well as a plan highlighting future performance goals and objectives which are quantified and time-specified. All performance evaluations should be documented and a copy of the evaluation should be given to the employee evaluated.

4.7.4 PROGRAM REPORTS AND REPORTING REQUIREMENTS

The administrative staff of HIV case management provider agencies should complete a quarterly case management program report which documents major program activities and accomplishments achieved during the previous quarter and areas requiring additional resources or program improvements. Program evaluation should be conducted on an ongoing basis. Case management data collected as part of grant reporting requirements should be utilized in evaluating case management services throughout the year.

4.7.5 QUALITY ASSURANCE

HIV case management provider agencies should develop a quality assurance program, which evaluates HIV case management services based on established case management standards. Quality assurance may include peer review, independent chart audits, and/or other measures of program performance which assess the quality, quantity and outcome/impact of case management services.

GLOSSARY

Appeal:	A formal request to reconsider a decision.
Client:	Any individual (and his/her defined support network), family or group receiving case management services. In some instances, the client may consist of an individual and his/her caregiver or an individual and his/her substitute decision-maker.
Community Services:	Services which are available within the community where the client lives. These services may be formal or informal.
Complaint:	Formal statement of concern about an activity or intervention.
Documentation:	Recorded information in the client file or other source documents.
Evaluation:	The process of determining the worth of or to appraise a service, resource, support or activity.
Goal:	Specific statement which describes a desired state for the future and provides direction for the day-to-day decisions and activities. Describes expected results (outcomes) of the service, support, resource, intervention or activity.
Indicator:	A performance measurement used as a guide to monitor, evaluate or improve the quality of case management or care. Indicators can relate to case management processes (key steps) and results (outcomes).
Need:	Physiological, psychological, or social requirement for well-being. May or may not be expressed by the person in need and are different from the demands which are expressed desires and not needs.
Outcome:	The consequence or impact of an intervention which may or may not be intended.
Process:	Series of interrelated activities and communications that accomplish a specific function.
Resource:	A term used to describe something tangible that is supplied to or can be accessed by the client to help achieve goals. It is often less formal or less defined than a service.
Service:	A term used to describe a more formal well-defined group of activities intended to accomplish a specific task.
Service Provider:	An individual or organization that provides a service to the client.

Support: An activity or intervention that encourages, strengthens, or otherwise helps a client care for himself/herself. Supports can be formal or informal.

Standard: A recorded statement of expected performance.

ACUITY ASSESSMENT

This form is issued under 252.12 (2) (a) 8 WI. Stats. Personally identifiable information is collected to assist case managers in planning and coordinating services for persons with HIV infection (and will be used only for that purpose). Completion of this assessment is voluntary however to determine case management service level an acuity score is necessary.

GENERAL INFORMATION

Client Name	Client ID Number	Today's Date
Case Manager Name	Case Manager Telephone Number ( )	
Agency Name		

ACUITY ASSESSMENT

Category	3 Points	2 Points	1 Point
Other Medical Needs ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Numerous or rapidly changing medical needs such as; home health care, medical supplies, medication, and transportation due to medical needs. Chronic hospitalizations or hospitalization within the last 30 days. **If warranted, explain other reason for score in notes section below**	Some need for treatment of non-HIV related symptoms. Minor conditions requiring treatment. **If warranted, explain other reason for score in notes section below**	Medically stable. Chronic condition under control with medication/treatment.
HIV Disease Progression ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Numerous or rapidly changing HIV related medical needs such as; home health care, medical supplies, medication, and transportation due to medical needs. Client is rapidly approaching terminal stages of the disease/and is close to death. **If warranted, explain other reason for score in notes section below**	Symptomatic; one or more Opportunistic Infections (OI): ranging from fair to poor health. Advanced disease status, no current support needs. **If warranted, explain other reason for score in notes section below**	Asymptomatic. Accessing early intervention /medical care provider.
Living with HIV ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Crisis care interaction for primary medical care or social service need(s). Frequently missed appointments, treatments, or medication regimens. Requires intensive follow-up for education about care and treatment, social service or community service issues. **If warranted, explain other reason for score in notes section below**	Aware of medical and community resources. Some missed appointments. Requires some follow-up for updated care/treatment issues. Moderate self advocacy skills. **If warranted, explain other reason for score in notes section below**	Regularly attends appointments. Requires minimal follow-up for information and referral; aware of treatment complexities, and service availability. Strong self advocacy skills.
Mental Health ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Active chaos or problems due to violence or abuse. Active crisis occurring; suicidal, homicidal. Acute psychiatric problems or dementia. Requires therapy, not accessing it. Requires significant emotional support. Significant trouble getting along with others. **If warranted, explain other reason for score in notes section below**	History of mental illness, violence/abuse, psychological disorders or psychotropic medications however connected with treatment. Is receiving therapy. Requires some emotional support. Has some trouble getting along with others. **If warranted, explain other reason for score in notes section below**	No history of mental illness, violence/abuse, psychological disorders, or psychotropic medications. No need for counseling referrals. Actively seeks structured support systems.

Category	3 Points	2 Points	1 Point
Income/Benefits and Entitlements ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	No income, no previous application for benefits; benefits denied; unfamiliar with application process and/or unable to apply without guidance. No health care insurance. Immediate need for emergency financial assistance. Ineligible for benefits or entitlements. **If warranted, explain other reason for score in notes section below**	Has steady source of income which is in jeopardy; occasional need for financial assistance or awaiting outcome of benefits application, has short-term benefits. Health care insurance inadequate. Return-to-work needs. **If warranted, explain other reason for score in notes section below**	Income stable and sufficient. Able to meet monthly financial obligations. Stable health care insurance, HIRSP and or AIDS Drug Assistance Program (ADAP) recipient.
Substance Use ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Active substance use causing major impairment of client/family member that interferes with social/ occupational functioning. Indifference regarding consequences of substance use. Disconnected from or no motivation to seek treatment. **If warranted, explain other reason for score in notes section below**	Problems with alcohol or drugs that interfere with function; expresses desire for help in overcoming drug use. Less than one year sobriety. Immediate family member with alcohol/drug problem. **If warranted, explain other reason for score in notes section below**	No current substance use/ or use with minimal functioning impairment.
Housing ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Homeless, evicted, no place to stay. **If warranted, explain other reason for score in notes section below**	Living situation unstable. Imminent eviction, living in shelter or uninhabitable home. Formerly independent person temporarily residing with friends or relatives. **If warranted, explain other reason for score in notes section below**	Stable living. Needs Housing Opportunities for Persons With AIDS (HOPWA) re-assessment. Has Section 8 voucher.
Activities of Daily Living (ADLs) ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Needs help with accessing assistance programs. Needs frequent help with food and clothing needs. Needs greater than 10 hours/week of in-home ADL assistance. Client is developmentally delayed and needs significant assistance with everyday functioning. **If warranted, explain other reason for score in notes section below**	Sustenance needs met on a regular basis with some periods of lapse. Partial access to assistance programs for food and household items. Past difficulty accessing assistance programs. Needs 10 hours/week or less of in-home ADL assistance. **If warranted, explain other reason for score in notes section below**	Food, clothing and other sustenance items available through clients' own means. Accessing food assistance programs. Able to perform all necessary activities of daily living.
Support System ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Recent loss of primary emotional support (significant other). Absent, overburdened or poor support system. Child/adolescent has dropped out of school or there are significant school issues including disclosure issues, acting out issues and/or significant neurocognitive needs. **If warranted, explain other reason for score in notes section below**	Inconsistent or no dependable support system; few individuals aware of client's HIV. Periodic support from various sources (e.g. AA, NA, etc). Child/adolescent has erratic school attendance, other school difficulties such as disclosure issues, or is involved in a team evaluation. **If warranted, explain other reason for score in notes section below**	Supportive significant other, friends &family that are aware of client's HIV infection. Child/adolescent attends school on a regular basis with no outstanding issues.

Category	3 Points	2 Points	1 Point
Transportation ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Lack of transportation is a serious contributing factor to current crisis. No public or private transportation available or client is uncomfortable using it. **If warranted, explain other reason for score in notes section below**	Inconsistent transportation. Needs occasional assistance with finances for and/or arranging transportation for medical/AODA/mental health appointments. **If warranted, explain other reason for score in notes section below**	Has own or other means of transportation consistently available; can drive self; can afford and is comfortable using private or public transportation.
Legal ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Incarcerated. Unaware of standard documents; i.e. living will, medical power of attorney, permanency planning. Undocumented immigrant. Crisis involving legal matters, e.g. legal altercation with landlord or employer. **If warranted, explain other reason for score in notes section below**	Wants assistance completing standard legal documents. Possible recent or current legal problems. **If warranted, explain other reason for score in notes section below**	No recent or current legal problems, all pertinent legal documents completed.
Access to Care ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Mobility, vision, or hearing impaired and requires accompaniment to appointments. No reliable means of communications between case manager and client. Client has no phone and/or can not read or does not want mail going home. Ineligible for medical/treatment services. **If warranted, explain other reason for score in notes section below**	Requires some assistance with accompaniments (crutches, wheelchairs, dependent on weather). Client has no telephone, but is able to receive mail and communicates with case manager when assistance is needed. **If warranted, explain other reason for score in notes section below**	Reliable and regular communication between case manager and client. Requires no assistance.
Culture/Language ☐ **(If client is a child or adolescent criteria pertains to client and/or caregivers)**	Non-English speaking with no interpreter services in the home. Lack of understanding of service system/language creates state of fear/anxiety and distrust in client and/or family; crisis intervention is necessary. **If warranted, explain other reason for score in notes section below**	Needs interpreter services arranged for health care/social service appointments. Family needs HIV education / interpretation to provide support. Understands service system. **If warranted, explain other reason for score in notes section below**	Non-English speaking with consistent interpreter services available. Understands service system. Requires minimal assistance. Reliable and regular communication between case manager and client.
Dependents/Children ☐	Client is single head of household and/or client's parent chronically ill. Actual/suspected child abuse. Division of Child Family Services (DCFS) involvement. Family with greater than 5 children. **If warranted, explain other reason for score in notes section below**	Two caregivers without supportive others and 3–4 children. Dysfunctional adult children. **If warranted, explain other reason for score in notes section below**	Two caregivers and 0-2 children with support. Children in uncontested DCFS custody.

ACUITY SCALE

TOTAL SCORE	FREQUENCY OF CONTACTS
14-23	**Quarterly direct client contact. Telephone contact acceptable. Annual home visit recommended. Biannual acuity review and annual reassessment required**
24-33	**Monthly direct client contact, telephone contacts acceptable. Annual home visit recommended. Significant amount of collateral contacts. Biannual acuity review and annual reassessment required.**
34-42+	**Bi-weekly direct client contact, telephone contact acceptable and intensive collateral coordination with other agencies/providers. Biannual acuity review and annual reassessment required.**

ACUITY SUMMARY

Client Name	Client ID Number	Today's Date
Case Manager Name	Agency Name	

1. ☐ **Other Medical**

2. ☐ **HIV Disease Progression**

3. ☐ **Living with HIV**

4. ☐ **Mental Health**

5. ☐ **Income/Benefits**

6. ☐ **Substance Use**

7. ☐ **Housing**

8. ☐ **Activities of Daily Living**

9. ☐ **Support Systems**

10. ☐ **Transportation**

11. ☐ **Legal**

12. ☐ **Access to Care**

13. ☐ **Culture/Language**

14. ☐ **Dependants/Children**

15. ☐ **Total Acuity Score**

Explain the reason for additional points referencing category number

Wisconsin AIDS/HIV Program
Bureau of Communicable Diseases
Division of Public Health
Wisconsin Department of Health and Family Services
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Madison, WI 53701-2659